Dragonfly Dental

PATIENT INFORMATION

First Name: _____ M: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email: _____ SS#: _____ Birthdate: _____

Secondary Address: _____ City: _____ State: _____ Zip: _____

(Circle one)
Gender: Male Female Marital Status: Married Single Divorced Widowed

Preferred Contact: Home Cell Work Email

Preferred Confirmation Method: Email – Yes or No Text – Yes or No Phone – Yes or No

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Employer: _____
SS#: _____

EMERGENCY INFORMATION

Name: _____
Phone: _____
Relation to Patient: _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____
Insurance Company: _____
Address: _____
Insured's Employer: _____
Insured's SS# _____
Group # _____
Insured's Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Insured's Name: _____
Insurance Company: _____
Address: _____
Insured's Employer: _____
Insured's SS# _____
Group # _____
Insured's Date of Birth: _____

CONFIRMATION

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist and any other member of his/her staff responsible for any action that they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient (or parent) _____ Date: _____